# Iowa Department of Human Services

## Offer #401-HHS-003: Medical Assistance, Contracts, IowaCare and HIPP

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| **This offer is for:** (choose one) | | **This offer includes the following appropriations:** |
|---|---|---|
| | New activity | Medical Assistance, Medical Contracts, IowaCare, |
| **X** | Status quo existing activity | HIPP, General Administration, Field Operations |
| | Improved existing activity | |

## Result(s) Addressed:

### Primary Results

- Improve Iowans' Health
  - All Iowans Have Access to Quality Care including:
    - Preventive Care
    - Primary Care
    - Acute/Emergency Care
    - Long Term Care

## Program Description:

The Medicaid program provides health care to Iowa's most vulnerable populations: low-income children, frail elderly, disabled persons, pregnant women and very low-income parents. This includes women who have been screened and diagnosed by the Breast and Cervical Cancer Early Detection Program (BCCEDP) and women participating in the Iowa Family Planning Network.

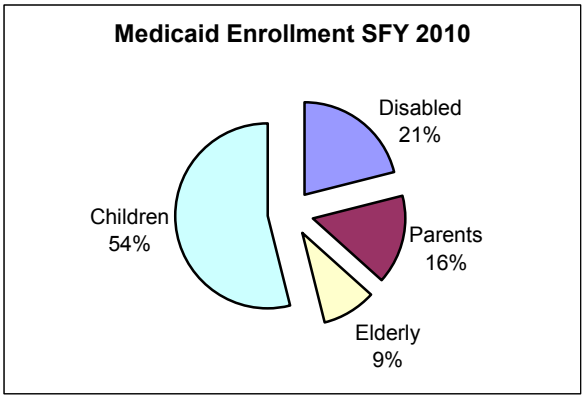
The Medicaid program is a partnership between the state and the Federal government and is financed by state and Federal matching funds. For every $1 Iowa spends, the Federal government matches about $2 (Federal match rate 62.40% in SFY 2009). With program expenditures of over $3.4 billion, matching funds for SFY 2010 will bring more than $2.0 billion Federal dollars into the State. The majority of the State share comes from appropriations from the State General Fund -- $778 million. The remaining State funds include $115 million from Tobacco funds, $112 million from the Senior Living Trust Fund, $175 million from county funds, and $220 million from other revenues such as recoveries and drug rebates. Other appropriations within the DHS budget are made to the counties that they can use to offset their Medicaid State match costs. Medicaid is an entitlement program, so states primarily control expenditures by either changing the eligibility requirements, the services covered, or the reimbursement rates to providers.

In order to be eligible for Medicaid, individuals must not only be low-income, they must also be either children, frail elderly, disabled persons, pregnant women, or very low-income parents. This leaves many single persons and couples without dependent children ineligible for Medicaid, even if they have no income. The IowaCare program was started in SFY 2006 to provide a limited health care benefit for low-income individuals who are not eligible for traditional Medicaid.

Iowa has undertaken innovative approaches to managing these programs and improving the quality of services. Iowa seeks to not simply be a payor of health services, but to manage high quality and cost-effective health care. The Iowa Medicaid Enterprise operates the Medicaid and IowaCare programs by integrating "best in breed" private contractors to efficiently process medical claims, work with providers and members, and aggressively pursue cost recovery. The Health Insurance Premium Program (HIPP) purchases private health insurance for members if cost-effective. In addition, Iowa has adopted many new and innovative programs to achieve these goals, including disease management programs, smoking cessation coverage, an electronic health record, preventive medical exams, multi-state drug purchasing pool, Preferred Drug List and premiums.

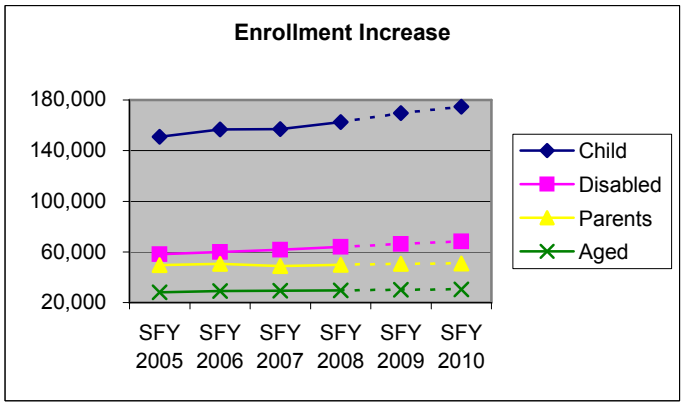
## Who:

The Department of Human Services estimates that the Medicaid program will have more than 483,000 individual Iowans enrolled over the course of SFY 2010. This program provides health care coverage for over 16% of Iowa's population at some point during a year. Medicaid will provide health care coverage for 260,322 children; 75,819 low-income parents; 101,951 disabled; and 45,392 elderly persons.




These enrollment figures include persons enrolled in one of three programs that provide limited benefits.

- For persons who are Qualified Medicare Beneficiaries (QMB), Medicaid covers only the cost of Medicare premiums, deductibles, and co-payments.
- The IowaCare program is limited to inpatient and outpatient hospital services, physician services, and limited dental and transportation services. The program also has a limited provider network. In SFY 2010, the IowaCare program is expected to cover 35,434 adults.
- Women in the Family Planning Waiver receive only family planning services. A projected 22,682 women will receive these services in SFY 2010.

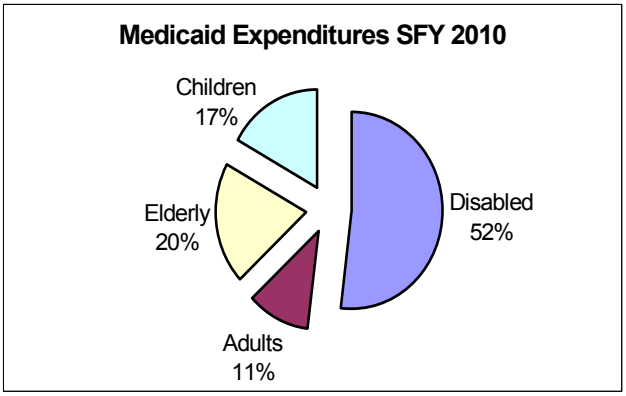



Average monthly enrollment in the regular, full-benefit Medicaid program is estimated to be 324,232 for SFY 2010. Overall enrollment in Medicaid has been increasing each year since 1996. While enrollment for parents and the elderly has remained stable, there has been a small increase for the disabled. The largest growth in recent years is for children. This increase is due to new efforts to inform families about the ***hawk-i*** program. The ***hawk-i*** program provides health care coverage to children whose families have too much income to qualify for Medicaid but who do not have health care coverage. When a family applies for ***hawk-i***, eligibility for Medicaid is checked. If a child qualifies under regular Medicaid or under the Medicaid expansion guidelines, they are enrolled in Medicaid. If a child does not qualify for Medicaid coverage, but does qualify for ***hawk-i***, they are enrolled for ***hawk-i*** coverage. During SFY 2008, 8,994 previously uninsured children were enrolled under one of these options. The majority of those, 7,889 children, were enrolled in Medicaid; 788 were enrolled in Medicaid expansion and 317 were enrolled in ***hawk-i***.

## What:

Iowa Medicaid pays for medically necessary health care services, including acute care services typically covered in any health insurance program. These include hospitalization, physician and advanced registered nurse practitioner (ARNP) services, dental care, emergency transportation by ambulance, laboratory, x-ray, and other services. Medicaid has become the largest single Federal funding source to states and has a significant impact on Iowa's economy. The Medicaid program has a panel of more than 30,000 dedicated providers including hospitals, physicians, dentists, pharmacies, medical equipment providers, and many other health care providers of all types.

In addition, Medicaid provides coverage for long-term care services, such as nursing home care, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and home and community based care that allows individuals to stay in their own homes or other small congregate settings. Long-term care services provided at home, such as home health, assistance with personal care, homemaking, and respite care allow individuals to avoid or delay institutional care.




The cost of medical care for different Medicaid populations varies significantly. The average cost for each child in Medicaid is much lower than the average cost for each disabled or elderly person, since elderly and disabled individuals utilize more long-term care services. As shown in the chart to the left, although children make up 54% of the Medicaid population, they account for only 17% of total expenditures. This difference is true nationally as well.

## How:

Medicaid, as a payor of health care services, has all of the same responsibilities as any third party payor such as paying providers' claims for services, but also includes the responsibility for quality monitoring of long-term care services.

The Iowa Medicaid program is administered by the Iowa Medicaid Enterprise (IME), which is composed of nine performance-based contractors whose activities are overseen and directed by staff from the Department of Human Services. The goal of the IME is to make Iowa Medicaid a well-run managed care organization, placing an emphasis on achieving and maintaining a high level of health and wellness for members.

Staff in other areas of DHS such as Field Operations and General Administration also support the operations of the Medicaid program. Field staff process applications and determine Medicaid eligibility. General Administration provides financial and accounting services, eligibility policy, personnel services, procurement, and information technology support.

## Offer Description:

### Today's Activities and Results:

This offer includes the Medicaid Program, Health Insurance Premium Program, IowaCare, and the Iowa Medicaid Enterprise (Medical Contracts). The offer maintains the current eligibility levels and covered services for recipients of Medicaid and IowaCare.

Under Federal regulations, state Medicaid programs are required to provide specific services, for specific populations. These are referred to as "mandatory" services. There are additional services that may be provided at the State's option, called "optional" services. "Optional" is really just a regulatory distinction as these services are not "optional" from the perspective of providing appropriate health care services. This offer continues both the mandatory and optional services Iowa provides. This offer assumes no increase in provider reimbursement in SFY 2010, except rate adjustments currently required by Iowa statute or regulation.

Overall, this offer includes an increase in General Fund support of $66,065,417 for SFY 2010. The majority of this increase is the result of the following:

- $67,945,143 for increases in the Medical Assistance program due to replacing one-time funds, increases in enrollment and utilization, and inflation:
  - $16,946,624 for growth in the utilization of fee-for-service (such as hospital, physician, laboratory, etc.) and inflation in cost-based reimbursement.
  - $12,125,069 for enrollment growth of 2.42% over SFY 2009.
  - $9,000,000 to replace funding at the Clarinda, Cherokee, Independence, and Mt. Pleasant Mental Health Institutes (MHIs) that was formerly provided through the IowaCare program. Pursuant to the Federal terms and conditions of the IowaCare waiver, the Federal funding is eliminated for MHIs in SFY 2010.
  - $7,930,958 for increases in Medicare-related payments. This includes growth in the payment of Medicare Part A and Part B premiums, the Medicare Part D clawback payment, and payments for Qualified Medicare Beneficiaries (QMBs).
  - $5,560,627 for the home and community based waivers, including $2,850,758 for annualization of one-time funds for the wait list buy-down that occurred in SFY 2009 and $2,709,869 for utilization growth and enrollment growth in the Elderly waiver.
  - $477,444 to continue three services, Crisis Intervention, Behavioral Programming, and Mental Health Outreach, in the HCBS Brain Injury and Mental Retardation waiver programs in SFY 2010. The services would be added to the Ill and Handicapped Waiver the following year.
  - $5,623,541 for Nursing Facility services due to rate re-basing in SFY 2010.
  - $3,819,318 to restore one-time funds in the SFY 2009 budget. This includes $3,195,318 from one-time Brain Injury Waiver funds and $624,000 in one-time Property Tax Relief funds.
  - $2,296,164 for certain mental health services. This is primarily due to utilization increases in Remedial Services, which in the past were available only to children in the child welfare system but are now available to all children who are eligible for Medicaid. Also contributing to the increase are growth in the Iowa Plan, habilitation services, Psychiatric Medical Institutions for Children (PMICs), and psychiatric services.
  - $1,833,333 to annualize partial-year funding provided in SFY 2009 for the hospital rebase.

- $988,923 for increases in Targeted Case Management services for both member and utilization growth.
- $1,343,145 for all other Medical Assistance program increases.

- In addition, the increase includes $2,156,730 for Medical Contracts due to inflationary increases required per the contracts, operational costs, and Information Technology increases; Federally mandated activities and systems changes including HIPAA version 5010, electronic attachments, and MMIS vendor procurement; and contracting with the Iowa Department of Public Health for Early Periodic Screening, Diagnosis and Treatment (EPSDT) case management services.

- $151,978 for additional inflationary costs to sustain operations and service delivery including worker's compensation fees, contract increases, printing, postage and Information Technology (IT) support. This includes $22,419 for Medical Contracts and $129,559 for the Medicaid portion of these costs for Field Operations.

- $848,610 for Field support for Medicaid. This maintains 18.52 field staff in order to timely and accurately determine eligibility for Medicaid and IowaCare caseloads. Medicaid caseloads are expected to increase by 7,273 (3.52%), and IowaCare caseloads are expected to increase by 6,000 (22.49%).

- ($5,037,044) in savings from reprioritized budget items (see below).

## Reprioritization

This represents a decrease of ($5,037,044) due to a reprioritization of program expenditures:

- A decrease of ($2,287,044) to eliminate funding for the Demonstration to Maintain Independence and Employment Grant funding in both SFY 2009 ($1,143,522) and SFY 2010 ($1,143,522). DHS has received preliminary approval from CMS; however, the grant expires in SFY 2010 and there will not be sufficient time to implement the program. While there have been discussions in Congress about extending the grant, and we continue to fully support the program we proposed, it is unlikely the program will be implemented in SFY 2010. We request intent language be included in the Appropriations bill that, in the event funding becomes available for the program, the Department could move forward with beginning implementation.
- A decrease of ($1,750,000) as a result of including behavioral health drugs on the Preferred Drug List (PDL). This would allow the State to increase the collection of supplemental rebates. Behavioral health drug expenditures totaled $117,934,476 in SFY 2008, which is 50.9% of the Medicaid drug expenditures. Although they account for over half of the expenditures, Medicaid is currently prevented by State law from including them on the PDL. Behavioral health drugs are also very prone to "off-label" usage, which means being prescribed for a diagnosis that is not indicated for that drug, per the Federal Drug Administration. This package would also include new medically appropriate prior authorization standards to manage off-label usage. Management of the PDL, including development of medical criteria, is guided by a committee which is made up of community physicians and pharmacists.
- A decrease of ($1,000,000) to implement a Correct Coding Initiative. CMS developed the National Correct Coding Initiative (NCCI) in Medicare to promote national correct coding

methodologies and to control improper coding leading to inappropriate payments. The NCCI 'edits' are utilized by Medicare nationwide; correct coding is common in commercial payors also. These 'edits' identify when incorrect code combinations are reported on claims and prevent inappropriate payments. CMS has encouraged State Medicaid programs to incorporate a Correct Coding Initiative in their programs. IME will contract with a service provider who would review Medicaid claims daily, prior to payment, to identify coding errors. There would be a cost for the contract, and for changes to the Medicaid claims processing system. These costs would be offset by a savings in claims expenditures, for a net estimated savings of ($1,000,000).

## Improved Results Activities

The Medical Services offer does not propose any improved results.

## Offer Justification:

## Legal Requirements:

Federal regulations require any state that operates a Medicaid program to include, at a minimum, specific services for individuals who fit into defined categories. Federal regulations at 42 CFR 440.210 and 42 CFR 440.220 require that inpatient and outpatient hospital, physician, lab and x-ray, nursing facility, physician services, nurse midwife and nurse practitioner services must be provided. In addition, this requirement indicates attention to care for pregnant women. Further, the Iowa Code also defines the services and eligibility categories the Iowa Medicaid Program is required to cover. This offer maintains our statutorily required services and populations.

## Rationale:

**All Iowans have access to Quality Care**

In addition to the mandatory services described above, Iowa has elected to provide a myriad of optional services, which complement and expand quality of care ultimately delivered to its most vulnerable citizens. These include pharmacy, chiropractic, ambulance and dental services, among others described in this offer. Covering these optional services not only avoids more expensive medical interventions, it ensures that the 483,000 Iowans covered by Medicaid receive high quality, comprehensive health care services.

The offer will:

- Provide low-income children, adults (including parents), the disabled, the elderly and pregnant women with timely access to appropriate quality medical care.
- Bring more than $2.0 billion dollars into Iowa from the Federal government in SFY 2010. To assess the full impact of these dollars on jobs and income and State tax revenues, one should also take into account the "multiplier" effect of these Federal dollars. Also there are numerous Iowa communities where Medicaid is the largest third party payor for medical service providers who are key players in the local economy.
- Maintain the administrative infrastructure necessary to support a performance based, evidence driven system of quality acute, preventive and long-term care services.
- Help shift the balance from institutional long-term care to community based long-term care and from long-term care generally to healthy aging by building a more informed membership.

## Results:

| Result: | SFY 2008 Actual Level | SFY 2009 Projected Level | SFY 2010 Offer Level |
|---|---|---|---|
| Percentage of State long-term care resources devoted to home and community based care.<br><br>Medicaid strives to assure that members are receiving services in their communities whenever possible. The funds spent for all long-term care is compared to those spent for community services. | 23.7% | 25.2% | 26.7% |
| Proportion of 15-month-old children with 6 well-child visits. | 36.9%* | 42% | 42% |
| Proportion of children with an annual dental visit. | 45.6%* | 48% | 55% |
| Proportion of persons with asthma where appropriate medications are used. | 55%* | 60% | 75% |
| Proportion of women receiving prenatal care from the first trimester. | 68.9%* | 72.5% | 75% |
| State savings from pharmacy cost saving strategies, including PDL. | $24 million** | $24.5 million | $25 million |
| Savings from utilization and care management strategies.<br><br>The Medical Services Unit reviews requests for prior authorization to determine medical necessity and recommend alternatives. Data on changes and denials are used to develop a savings over what would have been spent without such oversight. | $6 million** | $7 million | $8 million |
| Savings from Surveillance and Utilization Review compared to contract cost.<br><br>This dedicated unit used nationally accepted standards to search the claims database and find instances where payments may have been made incorrectly. The amount of overpayment recoveries is set by the contract with the entity performing this function. | 414% | 350% | 350% |

| Result: | SFY 2008 Actual Level | SFY 2009 Projected Level | SFY 2010 Offer Level |
|---|---|---|---|
| Increase over the prior year in revenue collections from third parties.<br><br>The collections (including cost avoidance measures) for SFY 2008 were 39.33% higher than the goal. Overall, the enhancement of the goal from year to year as specified in this contract would appear sound. The contracted performance measure is 15%. | 20.9% | 15% | 15% |
| % increase in member satisfaction with administration of Medicaid program over prior year, based on survey results<br><br>A 2006 survey set the baseline measure. Over the life of the Member Services contract the IME expects the positive rate to increase by 5% each year. | 5% | 5% | 5% |
| % of members aware of Member Services<br><br>A survey is performed annually by the PPC. The 2007 study indicated that 43% were aware of the helpline. A more recent survey (2008) has been performed but results are still being tabulated. The increase is an optimistic but achievable demonstration of the effort to make members aware of this helpline. | 43% | 55% | 60% |
| % increase in provider satisfaction with the Provider Services Unit over prior year, based on survey results<br><br>The aggregate score for provider satisfaction in 2007 was 26.83%. The improvement for 2008 was 0.98 points which is a 3.65% increase. The goal of 5% per year in incremental improvement is appropriate. | 3.65% | 5% | 5% |

| **Result:** | **SFY 2008 Actual Level** | **SFY 2009 Projected Level** | **SFY2010 Offer Level** |
|---|---|---|---|
| % of clean claims accurately paid or denied on time.<br><br>The Federal requirement is for 90% of clean claims to be paid in 30 days and 100% in 90 days. The IME currently shows that the average payment delay for a clean claim is less than 10 days. | 100% | 100% | 100% |
| * Healthcare Effectiveness Data and Information Set (HEDIS) measures are used to describe these results and are gathered by the University of Iowa Public Policy Center (PPC) annually. These are compared with national standards and benchmarks. HEDIS data reports are currently only available for SFY 2007. Actual HEDIS data cannot be utilized until claims data has been finalized and that is generally determined by the PPC at 24 months following the fiscal year. The SFY 2009 and subsequent year goals are taken from the PPC report and recommendations for future year goals.<br><br>** Projected amount for SFY 2008. | | | |

These results assume the level of funding requested in the offer in all appropriations as well as full funding of salary adjustment. If funding is insufficient in either area, results to be achieved will be modified to reflect the impact.